MDCH Synopsis of Comments for CON Standards Scheduled for 2007 Review
Presented to CON Commission March, 13, 2007

NEONATAL INTENSIVE CARE SERVICES/BEDS (NICU) (Please refer to 2.23.07 MDCH staff analysis for additional detail - attached)			
All Identified Issues	Issue Recommended for Review?	Recommended Course of Action to Review Issues	Other/Comments
1. Review and recalculate bed need methodology	No	None at this time	The bed need methodology has been calculated three times in the last four years using 2005 data which remains the most current data
2. Modify the project delivery requirements to specify that providers be trained in neonatal/pediatrics	Yes	Review draft language developed by the department to require pediatric specialties	
3. Remove five (5) bed cap contained in expansion of service in Section 6(2)	Not at this time	Review utilization data	Data shows minimal utilization of this provision along with low occupancy rates. If data over the next few years supports a change, this can be a part of subsequent review of the standards
4. Make technical changes and updates that provide uniformity in all CON standards	Yes	Review draft language developed by MDCH staff	
Recommendation: The Department suggests that the Commission assign responsibility to Department staff to draft necessary technical changes to the standards for appropriate Commission review and public comment. The Department suggests no specific SAC or workgroup activity for the technical changes.			

Michigan Department of Community Health
MEMORANDUM
Lansing, MI

DATE: February 23, 2007

TO: Irma Lopez

FROM: Andrea Moore

RE: 2007 Review of Neonatal Intensive Care Services/Beds Standards

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Pursuant to MCL 333.22215 (1)(m) the Certificate of Need (CON) Commission is to "..review, and if necessary, revise each set of Certificate of Need standards at least every 3 years." In accordance with the established review schedule on the Commission Workplan, Neonatal Intensive Care Services/Beds Standards are scheduled for review in calendar year 2007.

Public Hearing Testimony

The Department held a Public Hearing to receive testimony regarding the NICU Standards on January 9, 2007, with written testimony being received for an additional 7 days after the hearing. Testimony was received from one (1) organization and is summarized as follows:

Spectrum Health

- Review the bed need methodology, due to the increase in the birth rates of premature infants and length of time since the methodology has been established and reviewed.
- Recommends that project delivery requirement in Section 11 (1)(c)(ix) and (x) require pediatric specialties, as apposed to the current general specialties.
- Recommends removing the five (5) bed cap from the expansion of service language in Section 6 (2), which allows a facility to expand beyond the bed need inventory for facilities with a high rate of transferred patients to the facility.

Bed Need Methodology

On June 9, 1995, the current bed need methodology was established utilizing the formula of 4.5 beds per 1,000 live births, taking into consideration the very low birth weight (VLBW) adjustment factor. Prior to 1995, the bed need methodology was 4.5 beds per 1,000 live births. While the methodology has been in place for 11 years, it is comparable to other states; a summary of the states reviewed is as follows:

State	Current Methodology
Mississippi	4 beds per 1,000 live births in each perinatal planning area. (1- Intensive Care Bed and 3-Intermediate Care Beds) • Minimum unit size is 15 beds.
Tennessee	8 beds per 1,000 live births in each neonatal service area. • Minimum unit size is 15 beds.
Virginia	4 beds per 1,000 live births in each perinatal service area. • Minimum unit size is 15 beds. • Required maintain occupancy level of 85%.
West Virginia	4 beds per 1,000 live births in each perinatal service area. • Level II NICU beds only at facilities with 1,100 deliveries per year.

The bed need methodology has been calculated three (3) times in the last four (4) years, most recently on December 15, 2006, utilizing 2005 data. The 2005 data is the most current data available to the Department. While the testimony from Spectrum Health suggested that the VLBW numbers have increased, upon review of the data, the VLBW numbers have stayed relatively the same and the total live births have decreased slightly over the four (4) year period. The birth rates and resulting bed need are as follows:

H.S.A.	2002 Data			2004 Data			2005 Data		
	Live Births	VLBW Births	Resulting Bed Need	Live Births	VLBW Births	Resulting Bed Need	Live Births	VLBW Births	Resulting Bed Need
1	64,626	1,165	329	64,362	1,199	329	62,450	1,228	333
2	9,116	116	33	9,312	142	39	9,083	117	32
3	9,992	131	37	10,499	135	38	10,471	160	44
4	19,759	289	82	20,277	306	84	20,112	281	77
5	8,200	149	42	8,161	145	40	7,714	111	31
6	8,083	124	35	8,072	107	30	7,918	126	35
7	4,970	39	11	5,059	50	14	4,950	40	11
8	2,709	23	7	2,830	25	7	2,758	22	6
TOTAL	127,455	2,036	576	128,572	2,109	581	125,456	2,085	569

While the methodology has been in place for 11 years, it is comparable to other CON States; the methodology has been calculated utilizing the must up-to-date data; it is recommended that no revisions be made to the bed need methodology.

Project Delivery Requirements

The project delivery requirements in Section 11 (1)(c)(ix) and (x) require the provision for on-site physician consultation services and provisions for highly specialized services. The current language is very broad and does not specify that the provider of the services be trained in neonatal/pediatrics. It is recommended that an additional clarification regarding training in neonatal/pediatrics would be beneficial and appropriate to the Standards.

Technical Changes and Updates

The Department is systematically modifying all Standards to achieve uniformity, as well as in preparation for the launch of the on-line application system. In addition, there are several technical changes that need to be made to these Standards to remove old terminology and clarify current language.

Expansion of Service

The expansion of service language, established June 9, 1995, in Section 6 (2) allows a facilities with a high rate of transferred patients to expand beyond the bed need inventory with a maximum of five (5) beds. After reviewing the facility activity for the previous five (5) years, the Department found that this language only been utilized by a few facilities. Additionally, the 2005 occupancy rates for NICU facilities were reviewed, see table below.

The 2005 occupancy rates are as follows:

H.S.A.	FACILITY NAME	CITY	FACILITY NUMBER	LICENSED BEDS	PATIENT DAYS 2005	OCCUPANCY RATE
1	St. Joseph Mercy Hospital Ann Arbor	Ann Arbor	81-0030	15	2,396	43.76
1	North Oakland Medical Center	Pontiac	63-0110	18	2,633	40.08
1	St. Joseph Mercy Oakland	Pontiac	63-0140	15	3,893	71.11
1	Port Huron Hospital	Port Huron	74-0020	4	488	33.42
1	University of Michigan Health System	Ann Arbor	81-0060	40	12,560	86.03
1	Oakwood Hospital	Dearborn	82-0120	30	9,531	87.04
1	William Beaumont Hospital	Royal Oak	63-0030	33	12,090	100.37
1	Providence Hospital & Medical Center	Southfield	63-0130	15	3,434	62.72
1	St. John Hospital & Medical Center	Detroit	83-0420	35	10,975	85.91
1	Children's Hospital of Michigan	Detroit	83-0080	42	6,924	45.17
1	St. John Detroit Riverview Hospital	Detroit	83-0034	15	2,543	46.45
1	Henry Ford Hospital	Detroit	83-0190	35	7,354	57.57
2	Edward W. Sparrow Hospital	Lansing	33-0060	30	9,786	89.37
3	Bronson Methodist Hospital	Kalamazoo	39-0020	45	13,834	84.23
4	Spectrum Health Hosp (Butterworth)	Gr. Rapids	41-0040	67	20,040	81.95
4	St. Mary's Medical Center	Gr. Rapids	41-0080	15	5,218	95.31
5	Hurley Medical Center	Flint	25-0040	44	12,776	79.55
7	Munson Medical Center	Traverse	28-0010	12	4,406	100.59
7	Northern Michigan Hospital	Petoskey	24-0030	12	874	19.95
8	Marquette General Hospital	Marquette	52-0050	10	3,034	83.12

* Sinai-Grace Hospital (83-0450), Hutzel Women's Hospital (83-0240) and Covenant Medical Center (73-0061) have been excluded from the above table due to missing or incomplete data.

It is recommended that the five (5) bed cap should be maintained given the minimal utilization of this provision and the occupancy rates.

Recommendations

In response to the Public Hearing testimony, the following is recommended:

- Maintain the current bed need methodology.
- Modify the project delivery requirements in Section 11(1)(c)(ix) and (x) to require pediatric specialties.
- Maintain the current expansion language in Section 6(2) to allow up to five (5) beds per facility utilizing the current formula.

Drafted changes to the Standards in accordance to the recommendations above, including the departmental technical changes and updates are attached. The Department could ask that the Commission review draft language for possible proposed action.